Supreme Court, U.S.
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No. 05-____

IN THE
Supreme Court of the United States

TELECARE CORP.,
Petitioner,

v.

MIKE LEAVITT, SECRETARY OF HEALTH AND HUMAN SERVICES; DEPARTMENT OF HEALTH AND HUMAN SERVICES; and CENTER FOR MEDICARE AND MEDICAID SERVICES,
Respondents.

On Petition for Writ of Certiorari
to the Court of Appeals for the Federal Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Since 1980, the Social Security Act has provided that when a person both has private health insurance and is eligible for Medicare, Medicare is a "secondary payer" of medical expenses. That is, Medicare is required to pay for only those expenses that the individual's health insurance plan does not cover. If Medicare nevertheless pays for expenses that the private plan should have covered, the federal government may demand reimbursement under 42 U.S.C. § 1395y(b)(2)(B)(iii) from any entity that is "responsible" for covering them under the private plan.

The question presented is:

Whether an entity that neither has contractually agreed to cover an individual's medical bills nor is contractually indemnified by an entity that has so agreed is "responsible" to pay for the individual's medical expenses under 42 U.S.C. § 1395y(b)(2)(B)(iii).

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 29.6, Petitioner states that no parent or publicly held corporation owns 10 percent or more of the stock of Telecare Corp.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Telecare Corp. respectfully petitions for a writ of certiorari to the United States Court of Appeals for the Federal Circuit in *Telecare Corp. v. Leavitt*, No. 04-1389.

OPINIONS BELOW

The opinion of the Federal Circuit is reported at 409 F.3d 1345 (Fed. Cir. 2005), and is reprinted at App. 1a-12a. The district court's order is unpublished and is reprinted at App. 22a-30a.

STATEMENT OF JURISDICTION

The Court of Appeals for the Federal Circuit issued its opinion upholding the dismissal of Petitioner's complaint on May 25, 2005. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant statutory provisions of the Social Security Act are reproduced at App. 31a-45a.

STATEMENT OF THE CASE

A. The Medicare Secondary Payer (MSP) Program

Medicare is a government-funded health insurance program operating primarily under Title 18 of the Social Security Act, 42 U.S.C. § 1395, *et seq.* It is administered by the Center for Medicare and Medicaid Services (CMS). Medicare pays for medical "items and services" that doctors, hospitals, and other health care providers supply to Medicare beneficiaries. 42 U.S.C. §§ 1395d, 1395k. Medicare beneficiaries are the elderly, disabled, or others who meet certain defined criteria. 42 U.S.C. § 1395c.

Originally, Medicare paid for medical items and services "without regard to whether they were also covered by an employer group health plan." *New York Life Ins. Co. v. United States*, 190 F.3d 1372, 1373 (Fed. Cir. 1999) (quoting *Health Ins. Ass'n of Am. v. Shalala*, 23 F.3d 412, 414 (D.C. Cir. 1994)). Beginning in 1980, as a cost-cutting measure, Congress "enacted a series of amendments designed to make Medicare a 'secondary' payer with respect to such plans." *Id.* These amendments, known as the Medicare Secondary Payer (MSP) provisions, state that, if an item or service covered by Medicare is also covered by a private health plan, the private plan is "primary" and Medicare is "secondary." Thus, when overlapping private and Medicare coverage exists, Medicare pays only if and to the extent it has a higher limit of coverage than the private plan. App. 2a. As one court put it, the secondary payer program "is intended to keep the government from paying a medical bill where it is clear an insurance company will pay instead." *Evanston Hosp. v. Hauck*, 1 F.3d 540, 544 (7th Cir. 1993); *accord Zinman v. Shalala*, 67 F.3d 841, 843 (9th Cir 1995).

Health care providers who supply a medical item or service to Medicare beneficiaries must decide in the first instance whether to submit a claim for payment to the Medicare system, to a private plan, or to the patient. To prevent improper billings, claim forms submitted to Medicare must indicate the existence of private coverage so CMS can independently assess its responsibility to pay. Medicare beneficiaries are similarly obligated to disclose any private coverage directly to the Medicare system. 42 U.S.C. § 1395y(b)(5)(D).

When a bill is submitted for payment, CMS is supposed to determine whether a private plan provides primary coverage. 42 U.S.C. § 1395y(b)(5). CMS, therefore, maintains a database of information about private health coverage, which is designed to link Medicare beneficiaries with private health plans. If the existence or extent of private coverage is in doubt, CMS can

request the necessary information from a variety of sources, including employers, who are statutorily required to provide it. 42 U.S.C. § 1395y(b)(5)(C).

If CMS nevertheless receives and pays a bill when private coverage applies, the Medicare system has several options to recover the money. All Medicare payments are conditional, so a doctor, hospital, or other provider who is paid by Medicare when private coverage applies must repay the funds. 42 U.S.C. § 1395y(b)(2)(B); 42 C.F.R. § 411.24. If Medicare pays for an item or service and the beneficiary also receives payment from another source, the beneficiary is similarly required to reimburse Medicare. 42 U.S.C. §§ 1395gg(a)–(b), 42 U.S.C. §§ 1395y(b)(1)(F). Medicare is also subrogated to the rights of "any individual, provider, supplier, physician, private insurer, state agency, attorney or other entity entitled to payment by a third party payer." 42 C.F.R. § 411.26; *see* 42 U.S.C. § 1395y(b)(2)(B)(iii)–(iv). Medicare may thus exercise any rights the patient or provider has to obtain payment under the beneficiary's private plan.

Finally, and most pertinent here, Medicare has a direct right of action to recover from entities that were "required or responsible" under the private plan to pay for the medical items or services in the first instance. 42 U.S.C. § 1395y(b)(2)(B)(ii). In relevant part, the statute provides that the government may recoup payment for a medical bill from:

> Any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan.

Id.

Until recently, CMS read the direct action provision to allow recovery from employers when the employers were self-insured – that is, when employers had obligated themselves to pay providers for their employees' health care – but not when they merely had sponsored or funded third-party health insurance for their employees. In 1995, in fact, the agency published instructions to its fiscal intermediaries directing them to pursue reimbursement claims from insurance companies or HMO's and not from employers unless they were self-insured. Department of Health and Human Services, Health Care Financing Administration, Program Memorandum, *Transmittal No. AB-95-9* (Aug. 1995). Sometime in the late 1990's, however, CMS reversed course and began demanding that even those employers that undertook no financial responsibility for their employees' medical bills pay Medicare for expenses it incurred under the secondary payer program. App. 11a, 46a-48a. It is this new recoupment practice that is at issue here.

B. The Instant Litigation

1. Petitioner Telecare Corp. is a family and employee owned business in California. It works with local, county, state, and other behavioral health organizations to provide services to adults who suffer from serious mental illness. Telecare makes available to its employees a prepaid health care plan from Kaiser Permanente Health Plan, an HMO. Under the terms of the plan, Telecare pays a premium to Kaiser, but Telecare "is not itself contractually obligated to pay health care providers for the[] medical services" covered by the plan. App. 3a. Some of Telecare's employees and their dependents are covered by Medicare, as well as the HMO plan.

In the late 1990's, the dependent of a Telecare employee incurred $1470.96 in medical expenses, for which Medicare initially paid. CMS later determined that the individual had private health coverage with Kaiser, and assumed that the Kaiser plan covered the items or services the dependent